AUTHORIZATION FOR PROTECTED HEALTH INFORMATION
CITY OF MEMPHIS PLANS

(A separate authorization must be used if the authorization is for psychotherapy notes.)

Participant Name: _____

SSN: _____ Date of Birth: _____

ADDRESS: _____

_____

I understand that I am under no obligation to sign this form.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information.

1. The following is a **specific description** of the health information I authorize be **used and/or disclosed**:
   (i.e. information related to my visit to Dr. Jones on 5/15/03)

   _____

   _____

2. The following **person(s) and/or organizations(s)**, or classes of persons and/or organizations are authorized to **use and/or disclose** the health information described above:
   (i.e. may be used disclosed by the City of Memphis)

   _____

   _____

3. The following person(s) and/or organization(s), or classes of persons and/or organizations are authorized to **receive** my health information **from** the person(s) and/or organization(s) **described above** and to **use/or disclose** such information for the **purpose listed below**.

   In making this request, I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plan, or health care clearing houses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.
   (i.e. my husband, John Smith)

   _____

   _____

4. My health information may be used and/or disclosed for the following specific purpose:
   (i.e. by claims, payments and inquires from now until December 31, 2003)

   _____

   _____

5. Your Rights with Respect to This Authorization:

By signing this Authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information, i.e. information that constitutes protected health information as defined in the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996, in the manner described below.

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. I am aware that I can obtain a copy of an authorization revocation form from the City of Memphis, Benefits Service Center at 125 N. Main Room 1B38, Memphis, TN 38103-2017.

I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified above have already made in reliance upon this authorization.

I understand that if I agree to sign this authorization, I must be provided a copy of it. I acknowledge that I have been given a copy of this authorization.

This authorization will expire on the earlier of the following:
(a) The date on which I am no longer enrolled in the Plans;
(b) the following date: _____ (month/date/year); or
(c) upon the occurrence of the following event(s) related to my health care or to the purpose(s) for the authorization _____ .

PARTICIPANT

I, _____ (print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____
Participant's Signature Date

PERSONAL REPRESENTATIVE

Name of Plan Participant: _____

Name of Personal Representative: _____

Relationship to participant or nature of authority (i.e. health care power of attorney or guardian – If by authority I understand that documents confirming this authority must be attached and my signing this form, I promise that I have the legal authority needed to do so.

_____

Personal Representative's Address: _____

_____

Personal Representative's Phone: _____

_____ _____
Personal Representative's Signature Date